SUFFOLK COUNTY DEPARTMENT OF HEALTH SERVICES
DIVISION OF COMMUNITY MENTAL HYGIENE

APPLICATION FOR CLINIC SERVICES

Fill in as much of this form as you can and bring it with you to the clinic.
Don't worry if you can't fill it all in. Someone will help you complete it at the clinic.

(Office Use Only)					
1st Appt:	Appt With:	Fee:	Date Set:	Patient#:	Suff:

Date of Application		Application Completed by	

Please print your name, home address and telephone numbers:

Name			Telephone:
Street			Home
Town	NY	Zip	Work

If your mailing address is different from above, please print below:

Street		
Town	NY	Zip

Your Sex: (mark)		Social Security Number	Date of Birth
Male	Female	- -	/ /

(Optional)

Your race:	White	Black	Hispanic	Amer. Indian	Other

(Optional)

Marital status:	Single	Married	Divorce	Separated	Widowed

Do you speak English?	Yes	No

If not, what language do you speak?

Years of education you completed?
(High School is 12)

School Name

Address

Are you a veteran?	Yes	No

Who referred you to the clinic?

Name:	Phone:

Agency:	Position:

Please continue to Page 2

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Do you have any significant medical conditions? (write none if none)

Health Problems	Current Medications	Doctor & Address

Do you have any physical handicaps?
If yes, please mark which one(s) below:

Yes	No

Walking		Hearing		Seeing		Other	
Mild	Severe	Mild	Severe	Mild	Severe	Mild	Severe

What are the main problems that caused you to come to the clinic?

(continue on back if necessary)

Who lives in the same house with you?

Name	Date of Birth	Age	Relationship to Patient (e.g. “wife”)

Person to contact in case of an emergency		
Relationship to you: (e.g. “Father”)		Telephone:

Please continue to page 3

Have you ever been treated for Mental Illness before?

Yes	No

If yes, please list the places you have gone to.

Facility Name	City	State	Dates From	Dates To

CLINIC APPOINTMENTS

The clinic will try to schedule your appointments as soon as possible. Please mark in the boxes below what times you can possibly come to the clinic. In general, the more times that you can give will make it easier for our staff to fit an appointment into your schedule.
Put an "X" in EACH possible time period you can come to the clinic.

Morning (9-12)	Early Afternoon (12-3)	Late Afternoon (3-5)	Early Evening (5-7)	Late Evening (7-9)

Are you employed?

Yes	No	Status: (e.g. – disabled, student, etc.)

Your Occupation:

Your Employer

Name:
Address

Is Your Spouse Employed?

Yes	No	Status: (e.g. – disabled, student, etc.)

Spouse's Occupation:

Spouse's Employer:

Name:
Address

Please continue to page 4

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Clinic fees are based upon the family's financial status. A clinic fee will be set based upon your family income and number of dependents. Insurance coverage, Medicaid, and Medicare will be used when possible to reduce your family's expenses. You cannot be denied services based on inability to pay. Insurance coverage, Medicaid, Medicare, and family income will have to be verified. Please bring copies of your last income tax return or other proof of income to the clinic so that an appropriate fee may be set.

Please complete as much of the financial information below as you can:

Primary Health Insurance Coverage: (if covered)	Company:
	Address:
	Policy No.:
Secondary Coverage: (if covered)	Company:
	Address:
	Policy No.:
Additional Coverage: (if covered)	Medicaid Number:
	Medicare Number:

Total Family Income (as shown on Federal tax return)		Number of dependents:	

Additional Information

If there is any information that you think would be helpful for the clinic to have that is not included in this application, please write this information in the space provided below:

Thank you for completing this form.